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LIVING WITH PRODUCTIVE DISCOMFORT: ETHICAL REFLECTIONS ON CRITICAL CARE MEDICINE

INTRODUCTION

The Medical Intensive Care Unit (MICU) has always been productively discomfiting for me. As an academic, I enjoy the privileged and celebrated opportunity to perch behind an oak desk, pour over philosophical literature – today Kant, tomorrow Mill, next week Rawls – and identify the pros and cons inherent to moral arguments that aim to capture – and subsequently remedy – the ills of an intentionally-designed social world gone rogue. I have reflected and written and taught about the most grievous of bioethical issues, sought after their “cures,” and delineated them structurally according to the best argument(s) available. But in the MICU, none of that matters – everything ever thought, ever “known,” about what the “right thing” is, and what it looks, smells, and feels like can be expeditiously thrown out the window.

DEATHS AND RESURRECTIONS

Within minutes of arriving on a rainy Monday morning for unit rounds, a 30-year-old gentleman with end-stage renal disease, surrounded by his family and closest friends, unexpectedly coded and, very shortly thereafter, expired. Though I had only been introduced to one of the twelve members of the group (11 third-year residents and one senior attending physician), it became clear that my rounds that day were bound to be much like the condition of its patients and the level of care they necessitated: critical and intensive.

After the group dispersed to tend to the patient, provide support for the family and friends, and contact case management to inform them of the newest “opening” on the unit, things normalized rather quickly. I am always struck by how warmly I am greeted in the MICU. (Spoiler: Not all clinicians are open to interdisciplinarity.) Intensivists are acutely aware of the complexity of the decisions they face, and are glad – in most cases, anyway – to welcome a new member to the clinical team. In many ways, the MICU gets at the heart of clinical ethics; it is where the sickest (adult) members of society come to be treated, cared for, and, if possible, restored to health. Every decision, both medical and moral, is vital in the MICU. There is no room for error on a unit that measures its success in resurrections.

ADJUSTING TO THE LINGUISTICS OF CLINICAL BIOMEDICINE

The language of the clinician is blatantly foreign to the philosopher, and no doubt to the rest of the professional world, too. Concepts such as “giving a bolus,” (a pushed dose of a particular medication, as opposed to one given via IV drip), “appreciating the abdomen” (feeling with one’s hands to discover inconsistencies in the stomach area), and “ameliorating bladder neck retraction” (you don’t want to know) are as common as “ontology,” “epistemology,” and “hermeneutics” for lovers of wisdom.

Medical teams often begin morning rounds by deliberating in concrete medical jargon, as is their custom, stage by stage (differential diagnosis; medication reconciliation; prognosis; etc.), and one organ group at a time (nephrology, neurology, gastroenterology, etc.). Toward the very end (almost as if least important), the attending will ask: “What about the social factors pertinent to this case?” Ears now burning, this is my cue to listen closely. Frequently, the social issues are not atypically pressing (e.g., the family agrees with the proposed course of intensive care treatment and the infirmed individual is to be discharged to a nursing home facility in the very near future). Less frequently, the issues raised in the context of critical care are quite pressing – pressing for almost all members of the clinical team: medicine, nursing, social work, and spiritual services alike.

“YOU’RE THE ETHICIST: WHAT’S THE RIGHT THING TO DO?”

After digesting the medical terminology as best I can and adjusting to the sounds, smells, and emotional distress that perpetually fill the drab halls of the MICU, I am typically called on to deliberate outside of individual patient rooms. Several years prior, I had naively imagined that MICU rounds would be very different. I imagined meeting the patients themselves (if awake), speaking with their families and friends while in the room, and ascertaining their various points of view. But, in the MICU, almost all of the patients are incapacitated, sustained by mechanical ventilation and artificial nutrition and hydration (administered through a PEG tube), critically ill and diseased. To my surprise, many, if not most, are not surrounded by family and friends – just the sounds of chirping dialysis machines and slow drips from PIC lines. Even the residents hesitate to enter the patient rooms, going in only if explicitly petitioned, and often with protective gear à la Molokai Island.

When addressing a complex case in the MICU, I’m frequently asked: “What’s the right thing to do? Should we continue providing this treatment? It’s expensive, and I’m not sure it’s helping him, or ever will. But the family wants it, and it’s increasingly difficult to say ‘no’ to them. They become upset very easily, and it seems like the lesser evil to just continue catering to them.”

Catering to a family who persists in the request for non-beneficial treatment can often feel like the “least bad” thing to do from the standpoint of personal distress. However, it does not follow from this feeling that non-beneficial treatment suddenly becomes the more medically or morally reasonable choice. Clinicians are increasingly troubled by what they feel they “have” to do by virtue of external, highly litigious pressures. But offering an intervention that is not in the best interest of the patient is a flight from moral responsibility, not an enactment of it. Of course, this is much easier said than done. Explaining to a mother and father that “I, Dr. X, will no longer provide a treatment necessary to maintain the biological life of your beloved daughter because it is medically – and therefore morally – contraindicated” is no easy task. Yet it is, no doubt, a necessary, reasonable, and responsible one.

MORAL OF THE STORY

The herculean work accomplished in the MICU demonstrates first hand the art and science of good communication: that equally important as what one says – “we believe that X should be done for Y and Z reasons,” – is how one says it. The late poet Maya Angelou astutely noted that people will frequently forget what we say and do, but they will not forget – perhaps they will only ever remember – how we make them feel. So it is with the consulting in the MICU. Unless the ethicist is able to meet the most vulnerable members of society, whether patients or the families thereof, in the midst of their suffering – ventilated, dialyzed, “trached and PEGed” – he or she will never be able to do the good work of healing. Suffering may, in many senses, be unavoidable, but honoring the life, wishes, and memory of the sufferer is a remedy that even the non-medical professional can provide.